

PHYSICAL FITNESS TEST REQUIREMENTS

Per Standards of N.H. Police Academy (N.H. Police Standards & Training Council)

Scores I	Scores Required to Pass at 35th %-ile (Entrance to Corrections Academy)											
	-	E - REP H PRESS	PUSH	I - UPS	SIT	- UPS	1.5 MIL	E TIMED UN				
P. C. P. M. C. P.		% of Body at to lift	-	number to plete	-	number to ete (in 1	-	maximum s allowed				
* C.	MALES	FEMALES	MALES	FEMALES	MALES	FEMALES	MALES	FEMALES				
18-29	0.96	0.58	27	22	37	31	13:06	15:49				
30-39	0.86	0.52	21	17	33	24	13:53	16:23				
40-49	0.78	0.48	16	11	28	19	14:47	16:59				
50-59	0.70	0.43	11	10	22	12	15:53	18:09				

Scores Required to Pass at 45th %-ile (Graduation from Corrections Academy)											
		- REP H PRESS	PUSH	<u>- UPS</u>	SIT -	· UPS		E TIMED UN			
det dangt		% of Body at to lift	-	number to plete	-	number to ete (in 1	-	maximum allowed			
A	MALES	FEMALES	MALES	FEMALES	MALES	FEMALES	MALES	FEMALES			
18-29	1.03	0.63	31	25	39	34	12:20	15:10			
30-39	0.90	0.55	25	20	36	26	13:22	15:47			
40-49	0.82	0.51	19	14	30	21	14:08	16:34			
50-59	0.73	0.45	14	13	25	16	15:08	17:29			

Note: Correctional Officers, and Probation/Parole Officers will be **required** to pass the Physical Fitness Test in order to gain entrance in the Corrections Academy and to attain / maintain certification as Law Enforcement Officers.

Note: Other staff members who attend the Corrections Academy are **expected to participate**, **to the best of their ability.**



PHYSICAL PERFORMANCE

Department of Corrections employees are required to complete the Corrections Academy held at Police Standards and Training. The following is an explanation of the various standards of performance, training components and requirements which are to be used in determining the capability of the applicant to participate in this program of instruction and work in the corrections environment.

Certified Officers:

Corrections Officers and Probation/Parole Officers are *required to pass* the physical fitness test and must be able to fully participate and successfully complete the physical training, unarmed self defense (defensive tactics) and weapons qualification components in order to be certified as a corrections officer under N. H. Police Standards & Training Council Rules.

Corrections Line Personnel:

Other D. O. C. employees are *encouraged to participate to the best of their ability* in the physical fitness test, unarmed self defense (defensive tactics) and physical training. Furthermore, they may participate in weapons familiarization rather than weapons qualification.

Self Defense

The following is a list of activities, movements, postures and positions that are included in the unarmed self defense (defensive tactics) and other classes conducted as part of the academy. Please note the implications to the musculo-skeletal system, especially stress to joints as this information is reviewed. Physical training also involves participating in "take down" techniques where the participants are "thrown" or fall down onto a mat. Finally, strenuous physical activities may increase the demand on the cardio-pulmonary and vascular systems causing increased heart rate, respiratory rate, and blood pressure.

bending	crouching	jabbing	lifting	punching	restraining	stretching
blocking	falling	jumping	marching	pushing	running	swinging
chopping	grasping	kicking	pivoting	reaching	spinning	thrusting
crawling	gripping	kneeling	pulling	resisting	squatting	twisting

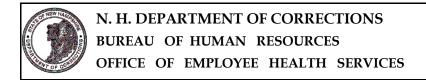
Incident Control: Oleoresin Capsicum (OC)

Oleoresin Capsicum (OC) is an agent used to subdue out-of-control inmates during altercations and disturbances. The components are comprised of an essential oil and a resin found in nature (oleoresin) and the active ingredient, which is a derivative of cayenne pepper (capsaicin). Departmental staff members are instructed in the safe handling of this agent and techniques to administer the agent to control volatile situations. This training is initiated in the Corrections Academy and as part of ongoing In-service Education programming. Students are exposed to OC by primary contact, such as aerosolized droplets or foam, and by secondary contact by handling objects contaminated by the agent. They are also taught how to properly treat areas that may have been exposed to the agent.

CORRECTIONS ENVIRONMENT

The Corrections environment is an environment where N. H. Department of Corrections staff members are in direct/close contact with convicted felons or psychiatric patients who may have a history of unpredictable or violent behavior; this requires the ability to maintain vigilance, the utilization of well developed observation skills and the capacity to respond rapidly to unexpected and/or emergency situations.

Other physical demands may include periods of prolonged standing, walking, or sitting, and occasional to frequent stair climbing.



Contents: Pre-assignment Physical Examination Packet

- 1. Physical Examination Menu
- 2. Release of Medical Information form
- 3. Instructions for the Completion and Distribution of Medical Evaluation Paperwork
- 5. Medical History form (three (3) pages)
- 6. Physical Examination form (three (3) pages)
- 7. Occupational Health Form
- 7. Pass for entry into a Department of Corrections facility
- 8. TB Screening / Immunization form
- 9. Medical Follow-up form
- 10. Audiology Recourse Testing form

Questions should be directed to your recruiter or Employee Health Services.

Physical Examination Menu

Name: _	
Position: _	
_	Physical Examination
_	Audiology Screening (for Officers only)
_	TB Screening: Mantoux (PPD) Symptom Check
	Urinalysis by dinstick

RELEASE OF MEDICAL INFORMATION

I authorize the N. H. Department of Corrections to provide copies of any or all records or reports resulting from my pre-assignment physical evaluation to include my medical history and physical examination, the results of laboratory or other tests (which may include third party disclosure), physician statements and the Occupational Health Form to the Staff of N. H. Police Standards and Training Council as part of application for enrollment in the Department of Corrections Academy.

Name	Signature	Date
Witness Name	Witness Signature	Date

<u>Instructions for Completion and Distribution of Medical Evaluation Paperwork</u>

YOU ARE RESPONSIBLE FOR FOLLOWING THESE DIRECTIONS AND INSTRUCTIONS

- 1. The forms in this packet must be completed **prior** to reporting to your appointment.
- 2. Responses **must be printed legibly** in blue or black ink using a **ball point pen**.
- 3. DO NOT LEAVE ANY BLANK LINES OR SPACES
- 4. Be sure that your **full name** and date of birth (DOB) are recorded in the spaces provided **on each page.**
- 5. If you have any questions, please ask before you leave for your appointment.
- 6. If you wear corrective lenses YOU MUST HAVE THEM WITH YOU for your appointment.

NOTE: If you wear contact lens you will be required to remove them for the examination. Please bring any necessary supplies with you to the appointment.

7. Medical History

Page 1

Item 4 Home address: be sure to include city or town and state

Item 5 Home phone: You **may also** include a work phone or cell phone

Item 6 Position: indicate the Position for which you are applying

Item 7 Purpose of Examination: indicate "Pre-assignment Physical Exam"

Item 10 Indicate any current medical conditions; write the names of **all** medications to include "over the counter" (OTC) , herbal or dietary supplements

Page 2

Items 17 through 26: If any of these categories are answered "yes" a detailed explanation is required; use the space to the right. PLEASE USE THE APPROPRIATE CORRESPONDING NUMBER TO LABEL EACH EXPLANATION

Page 3

Item 25: Read carefully and sign to confirm that your answers are accurate and complete

8. Occupational Health Form

You will be given the Occupational Health form by the examiner at the end of your appointment. You must retain this form and present it to the instructor on the day of your Physical Fitness Test.

NOTE: YOU WILL NOT BE PERMITTED TO TAKE THE PT TEST WITHOUT THIS FORM

9. TB Screening/Immunization Record and Pass

You will be given your TB Screening/Immunization Record and a Pass to admit you to one of the DOC facilities to have the TB Test read.

NOTE: Reading of the screening test is TIME SENSITIVE. If you fail to meet the time requirements the test is invalid. This screening is required for medical clearance.

Please return the completed TB form to EMPLOYEE HEALTH SERVICES OFFICE as soon as possible after the test is read.

MEDICAL CLEARANCE CANNOT BE COMPLETED WITHOUT IT

Mailing address: Street address:

PO Box 1806 105 Pleasant St., 3rd Floor Concord, NH 03302-1806 Concord, NH 03301

10. Information recorded on these documents is for official use only in order to determine if your health status will allow you to perform the duties required for the position for which you have applied.

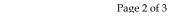
Questions should be directed to your recruiter or N. H. Department of Corrections Employee Health Services.

Pre-assignment Packet



1. Las	st Nam	е		First Nam	е	Mi	ddle N	ame 2	. Date of birth:	3. Social Security Number:
4. Hoi	me Ado	dress						5. Hom	e Phone:	6. Position:
7. Pur	pose c	of Examina	ition	8. Examination Date	9. Facility I					
					and Add	iress				
10 St	ato of	Vour Curr	ant Har	I alth and Medications (Fo	llow with do	scrintio	n of na	et hietory	if complaint or	condition still exists)
10. 3	ale oi	Tour Curre	5111 1 100	aitii and Medications (i c	mow with de	SCHPILO	i oi pa	St HIStory	ii compianti oi	Condition Still exists)
Medi	cations	and date	of last	dose: (Prescription or	OTC)					
					•					
		<u> </u>				1.0 5		(5)		,
	-	u ever (Pl	ease c	heck each Item)				(Please	check each iter	n)
YES	NO	والمناسب المحاسات				YES	NO	IM sou oil		at langua
		Coughed		ne who had tuberculosis					asses or contaction in both eye	
				od rafter injury or tooth exti	raction				hearing aid	85
		Attempted			action				r stammer hab	itually
		Been a sle								or other skin of support
13. H a	ave vo			you now have: (Plea	se check to	the left	of each			
YES	NO	Unknown		ndition or Symptom		YES	NO	Unknow		or Symptom
			Scarle	t Fever, erysipelas					Broken bones	S
				natic fever						wth of Cancer
				en or painful joints					Rupture or he	
				ent or severe headaches	3				Piles or Rect	
				ess or Fainting spells						painful urination
			Eye tr							ince 12 years old
				Nose or Throat trouble						or blood in urine
				ng loss					Sugar or albu	
				ic or frequent colds tooth or gum trouble		-	1			s, gonorrhea, chlamidia, etc or loss of weight
			Sinusi							imatism or bursitis
			Hay fe				1			or other deformity
				lisease					Lameness	or other deformity
				id trouble					Loss of a fing	per or toe
				culosis						ck" shoulder or elbow
			Asthm	ıa					Recurrent ba	
				ness of breath					"Trick" or loc	
			Pain c	r pressure in chest					Foot trouble	
				ic cough					Neuritis	
				ation or pounding heart						cluding infantile)
				trouble						nvulsions / seizures
				or low Blood Pressure					Car or sea or	
				os in your legs					Frequent trou	
				ach/Liver/Intestinal troub						r excessive worry
				ladder trouble or gall sto	nes		ļ			ble of any sort
				ice or Hepatitis	dui i ai a	14 5	ou four	l alaa anb		consciousness
				se reaction to serum or of allergies of any kind	urugs		NO		/Have you e	
List of	allorgi	00.	⊓ave	anergies or any kind		YES	INO	Unknown		for a menstrual disorder
LISE UI	anergi	. .								e in menstrual pattern
						Date	of last	ı I menstru	al period:	o in monoriuai pattem
						Dail	oi iusi		a. portou.	

ADM 39 Med Eval.xls: HX - 1 Rev 7-26-05 L Angelini





N. H. Department of Corrections Employee Health Services Medical History

Name:		-
DOB:	 _	

15 W	hat is v	your usual occupation:	16. Are you (circle one)
10. **1	iat io y	rodi adaa oodapanon.	Right handed
			Left handed
<u> </u>			
Check	each i	item yes or no. Every item checked yes must be fully ex	plained in the blank space provided on the right.
<u>YES</u>	<u>NO</u>	<u>CATEGORY</u>	EXPLANATION
		17. Have you been refused employment or been	
		unable to hold a job or stay in school because of:	
		A. Sensitivity to chemicals, dust, sunlight, etc.	
		B. Inability to perform certain motions.	
		C. Inability to assume certain positions.	
		D. Other medical reasons (If yes, give reasons)	
		18. Have you ever been treated for a mental	
		condition? If yes, specify when, where, and give	
		details.	
		19. Have you ever been denied life insurance? If	
		yes, state the reason and give details.	
		20. Have you had or have you been advised to have	
		any operations? If yes describe and give age at	
		which they occurred.	
		21. Have you ever been a patient in any type of	
		hospitals? If yes specify when, where why and the	
		name of doctor and complete address of hospital.	
		22. Have you ever had any illness or injury other than those already noted? If yes, specify when,	
		where, and give details.	
		-	
		23. Have you consulted or been treated by clinics, physicians, healers or other practitioners within the	
		past 5 years for other than minor illnesses? If yes	
		give complete address of doctor, hospital, clinic and	
		details.	
		24. Have you ever been rejected for military service	
		because of physical, mental or other reasons? If yes	
		give date and reason for rejection.	
		25. Have you ever been discharged from military	
		service because of physical, mental or other	
		reasons? If yes, give date, reason, and type of discharge: Honorable, Other than Honorable, for	
		Unfitness, or Unsuitability.	
		26. Have you ever received, is there pending, or	
		have you applied for pension or compensation for an	
		existing disability? If yes, specify what kind, granted by whom, what amount, when and why?	
		Wilder and a mount, which and willy:	





	Employee Health Services Medical History	Name: DOB:	
27. I atte	st the information I have provided	on the Report of Medical history form is complete and true to the best of my	

27. I attest the information I have provided on the R knowledge. I realize that deliberate falsification confurthermore, I understand that such falsification will may result in disciplinary action to include dismissal	stitutes fraud for which the law (N. H. RSA I disqualify me from further consideration a	638) provides penalties.
Printed name of Examinee	Signature	Date
28. Physician's summary and elaboration of all perti in items 11 through 24. The examiner may develor examinee and record significant findings below. Item # Comments	nent data. The examiner <u>must</u> comment op any additional medical history deemed in	on all positive answers aportant by interview with
Typed or printed name and address of examiner Name	Examiner's signature	
Address	Phone number FAX number	Date signed

→ Return to: Lisa Angelini, RN/CNA, BC Administrator, Employee Health Services

FAX (603)271-3345

Phone (603) 271-5661

E-Mai langelini@nhdoc.state.nh.u

NH Department of Corrections Employee Health Services PO Box 1806

Concord, NH 03302-1806



N. H. Department of Corrections Employee Health Services Physical Examination

1. Last Name		First Name		r	Middle Initial		2. Date of Birth		
3. General App	earance and Development	(Circle one)	Good Fai	ir Poo	or 4. Positio	n		Circle one	
5. Height withou		6. Weight wit			7			Group I Group II	
	Note: If applicant wears g	lasses or cont	act lenses, te	st and reco	ord results wi	th and with	hout		
	a. Distant Without acco	mmodation	R/20		L/20		B/20		
7. Visual	With accomr	nodation	R/20		L/20				
Acuity	b. Near Without acco	mmodation	R/20	_					
	With accomr	nodation	R/20		·				
				-	or perception:				
	e. Form Fields of vision:								
	Circle on	ne: Degrees o	f fields obtain	ned by in	nstrumentatio	on or	confrontatio	n.	
8. Eyes	a. Pupils: Shape:				action:				
o, o.	b. Evidence of disease or	injury:		c. [Fundoscopic:				
Г 	a. Nose:	b. Septum	n:	c	Teeth:		d. Gums:		
9. Head and	e. Pharynx:	-	s:		Soft Tissue:				
Neck	h. Thyroid:	i. Bruit:			Nodes:				
	k. Ears:	I. Tympa	nic Membran	es: Left	t		Right		
	Indicate testing method / instrument used:								
10. Hearing	Right Ear: 500 Hz		1000 Hz		2000 Hz		3000 Hz		
	Left Ear: 500 Hz		1000 Hz		2000 Hz		3000 Hz		
11. Chest	0.00			b. Mea	asurement:	Inspiration	n:		
	c. Axillary Nodes			·		Expiration	n:		
12. Lungs	a. Breath Sounds			c. Rub:					
13. Heart	a. Rate:		c. Sounds						
	Activity	Blo	od Pressure	Pulse R	ate Heart	t Sounds	Rhythm		
	a. At rest								
14. Cardio-	b. After moderate exe								
Vascular	c. 3 minutes post exe	rcise							
	Type and duration of ex	xercise used fo	r testing:						
	Explain significance of	of BP measure	ements abov	⁄e 145 Hg ଶ	systolic or 9	5 Hg dias	stolic in item	# 21.	
	Circulation to extrer	nities	Pulses	Color	Tem	perature	Edema	\neg	
	d. Left hand / radial							\neg	
	e. Right hand / radial							\neg	
	f. Left foot / pedal								
	g. Right foot / pedal								
	h. Note any abnorma	lities:							

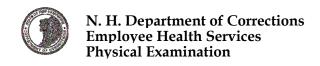




N. H. Department of Corrections Employee Health Services Physical Examination

Name:_			
DOB.			

	a.	Girth:			b. Sc	ars:		_	c. Bowel so	unds:	
15. Abdomen	d.	Palpation:				/er:			f. Spleen:		
	g.	Kidneys:	_		h. Ge	enitalia:		_	i. Hernia:		
16. Rectal	ТН	IS EXAM IS RE	COMMENDE	ED FOR	R IND	IVIDUALS	40 Y.	O. AND C	DLDER BUT	IS NOT REQU	RED
	a.	Fissure:	b.	Fistula	: <u> </u>		c.	Hemorrho	ids:		
		Test by bendi	ng, stooping,	R.O.M	. of up	per and lov	ver ex	tremities a	nd digits.		
		Body Part	Posture		oility	Symmetr		Function	Pain	Missing Parts	
17. Musculo-	a.	Neck									
skeletal	b.	Upper left									
	c.	Upper right									
	d.	Lower left									
	e.	Lower right									
	f.	Spine									
	a.	Rhomberg:		b. Pup	oillary:	Left:		Rig	ıht:		
18. Nervous	c.	Tendon Reflexes	Brach	<u>nial</u>	<u>F</u>	Radial	<u>P</u>	<u>atellar</u>	Achilles	<u>Plantar</u>	
System		Left side									
		Right side									
19. Labs &	a.	Urinalysis: Spo	ecific gravity:			Albumin:		Glucos	se:	Micro:	
Diagnostics		Bloodwork: Her								(R:	
20. Special Considerations			Yes	No about t	Expla this indeposit	in all posit dividual's al ures of Phys	i ve re oility to sical F	esponses i o participat Performanc	n Item # 22 te in Physical	g or examination? Fitness Testing o	
	Ex	planation of the s	•	•		•	nical f	indings:			
		Item #	Remarks & F	Recomm	nendat	tions:					
21. Remarks											_
											_
											<u> </u>
											_



Name:		
•		
DOB:	_	

	Certification of Medical Release:
22. Conclusion	Upon review of the Medical Standards of the NH Police Standards & Training Council as well as the Physical Performance Standards of the NH Department of Corrections, this certifies that the above named individual was examined by me on is in good health and is able to participate in the NH Department of Corrections Academy and the
	Physical Training Program Without restriction(s) or limitation(s). With the restriction(s) or limitation(s) of:
	is subject to further medical assessment by for the following reasons:
	He /she has been given: a Medical Follow-up Notice an audiology recourse testing packet a copy of Medical History & Physical Examination Other:
23. Examiner Identification and Signature	Typed or printed name and address of examiner Name Address: Phone number FAX number Date signed

<u>Return to:</u> Lisa Angelini, RN/CNA, BC

FAX (603) 271-3345

Phone (603) 271-5661 E-Mail langelini@nhdoc.state.nh.us

NH Department of Corrections Employee Health Services PO Box 1806 Concord, NH 03302-1806



STATE OF NEW HAMPSHIRE DEPARTMENT OF CORRECTIONS

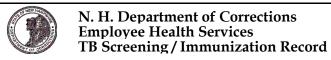
Lisa Currier Administrator

Human Resources Bureau P. O. Box 1806 Concord, New Hampshire 03302-1806 FAX: (603) 271-3345

Memorandum

(Pass for Entry into Depart. Of Corrections facility)

To:	FRONT DOOR OFFICER	Date
From:	Rod Greenwood Recruiting Lieutenant	At: NH DOC Recruiting Office Phone: 271-5645
Subject:	Reading of TB Screening Tes	t
-	rspective employeeer TB test read at:	needs to have
	NHSP-Men, Health Services Cen Phone: 271-1853 or 271-606	
	NHSP-Women, Health Services Phone: 668-6137, ext 311 or	
	Lakes Region Facility, Health Ser Phone: 528-9200 Location	
	Northern NH Correctional Facili Phone: 572-0345	ty, Health Services Center in Berlin
	DOC Headquarters, Employee H Phone: 271-5661	Iealth Services Office in Concord
Instruc	tions to Applicant: Report to	the above facility
	AFTERON	
	BEFOREON	(24 hour window)
		ST BE DONE AFTER 48 HOURS
	NO LATER TH	UT AN 72 HOURS
<u>REMI</u>	as soon as possible	pleted TB form to H SERVICES OFFICE NCE CANNOT BE COMPLETED WITHOUT IT



Name: _	-
DOB:	

								DOD				
		Al	lergies:									
Unknow	n											
Negative Positive	e		-	<u>Ac</u>	ctive TB Trea Meds:	tment [ate	es: fror	m		_ to	
Date:	_ - -		_		CG vaccination	<u>on</u> Da	te:_			i		
				TB	Screening	(Manto	ux)				
Date	e Adm.	by N	Nurse		Site	Lot #		Date I	Read	b	y Nurse	Result
			Ott	T 7	<u> </u>	<u> </u>		T				
(Type of Va	accine o	or Test)					ng		<u> </u>	Lot#	Comm	ents
(1)po 01 vo		7 1001)	Date Alai	···						201 11	001111	
			T R	Svi	mntom Ch	eck and	H	istorv	<u> </u>			
HCP:					_					(Comments:	
		_				Weigh	t los	s Y I	N	_		
HCP:					CXR Date:		Re	sults:		(Comments:	
		-				Weigh	t los	s Y I	N	_		
HCP:					CXR Date:		Re	sults:		(Comments:	
		•				Weigh	t los	ss Y I	N	_		
HCP:					CXR Date:		Re	sults:		(Comments:	
Produ	ctive Co	ough `	Y N	Hemo	ptysis Y N			_		_		
Chron	ic resp.	symptom `	Y N	Night	sweats Y N					_		
HCP:	ative O		. N					_		(Comments:	
		J				vveigh	ι 109	S Y I	N			
	Unknow Negative Positive Chest X-F Date: Result: Produ Chron HCP: Produ Chron H	Chest X-Ray Date: Result: Date Adm. Date Adm. Type of Vaccine of Chronic resp. HCP: Productive Concording resp.	Chest X-Ray Date: Result: Type of Vaccine or Test) HCP: Productive Cough Chronic resp. symptom HCP: Productive Cough Chronic resp. symptom	Unknown Negative Positive Chest X-Ray Date: Result: Date Adm. by Nurse Other Type of Vaccine or Test) HCP: Productive Cough Y N Chronic resp. symptom Y N HCP: Productive Cough Y N Chronic resp. symptom Y N HCP: Productive Cough Y N Chronic resp. symptom Y N HCP: Productive Cough Y N Chronic resp. symptom Y N HCP: Productive Cough Y N Chronic resp. symptom Y N HCP: Productive Cough Y N Chronic resp. symptom Y N HCP: Productive Cough Y N Chronic resp. symptom Y N HCP: Productive Cough Y N Chronic resp. symptom Y N	Chest reaction Provided Pro	Previous TB Treation Previous TB Treation Previous TB Treative Positive Active TB Treative Positive Active TB Treative Positive Active TB Treative Positive Positive Positive Active TB Treative Positive Positive	Criminate Company Co	Previous TB Treatment Date Meds: Positive Positive Positive	Allergies: Cin test reaction	Allergies: Continuest reaction		Allergies: Comments: Comments: Comments:



N. H. Department of Corrections Employee Health Services

Occupational Health Form

Name:		
DOB:	wgt:	

Physical Training Program Requirements of Corrections Academy

Training	Program
TIGHTILL	TIUSIAIII

Physical Fitness Test

Activity/Motion									
Run			Nun	nber to com	plete		Nun	ber to com	plete
Sit-ups			AGE	MALES	FEMALES		AGE	MALES	FEMALES
Push-ups			18-29	37	31		18-29	27	22
Climb			30-39	33	24		30-39	21	17
Reach			40-49	28	19		40-49	16	11
Grasp			50-59	22	12		50-59	11	10
Push			60+	18	5		60+	9	4
Pull			•			•			
Strike/punch									
Jump			1.5 MI	LE TIMEI	D RUN	ON	VE-REPE	TITION E	BENCH P
Twist			Min	utes to com	plete		Weig	ght requirer	nent*
Lunge			AGE	MALES	FEMALES		AGE	MALES	FEMALES
Pivot			18-29	13:06	15:49		18-29	0.96	0.58
Squat			30-39	13:53	16:23		30-39	0.86	0.52
Kneel			40-49	14:47	16:59		40-49	0.78	0.48
Bend			50-59	15:53	18:09		50-59	0.70	0.43
Crawl			60+	16:59	18:54		60+	0.65	0.41
Kick				•			* Multip	oly by body	/ weight
Fall to ground						•			$\overline{}$
Restrain another persor	1 <u> </u>						Bench pres	ss wgt:	
1 Is able to fully partic	ipate in	the Physical	Training P	rogram an	nd Physical	Fitness T	Testing as	indicated	lbs
1 Is able to fully partic	-	,		Ü	•		Ü		above
1 Is able to fully partic	-	,		Ü	•		Ü		above
1 Is able to fully partic	-	,		Ü	•		Ü		above
•	in the P	hysical Traii		Ü	•		Ü		above
 Is able to fully partic Is able to participate 	in the P	hysical Traii		Ü	•		Ü		above
 Is able to fully partic Is able to participate 	in the P	hysical Traii		Ü	•		Ü		above
Is able to fully partic Is able to participate	in the P	hysical Traii		m and Phy	•	ss Testin	Ü		above

ADM 32 Med Eval.xls: Occ Health Rev.7-26-05 L Angelini

	N. H. Department of Corrections Employee Health Services
T OF CO.	Medical Follow-up Notice

Name:		
DOB:		

	Follow-up by your personal Health Care Provider
	Input / clarification from your personal Health Care Provider
_	Further clinical evaluation and/or treatment for concerns or conditions noted below:
cal fir	ndings that warrant attention include:
	Laboratory results outside the normal range
	OF THE PROPERTY OF THE PROPERT
	Clinical findings that do not meet NH Police Standards & Training Council Medical Standards
	Recent medical condition/history that does not meet NH Police Standards & Training Council Medical Standards

PLEASE NOTE:

You <u>MUST</u> contact Lisa Angelini, RN/CNA, BC before you proceed with any follow-up activities indicated above. Failure to do so will result in delays in the hiring process.

Lisa Angelini, Administrator, Employee Health Services

Phone: (603) 271-5661

CC: NH DOC Employee Health Services File

ADM 33 Med Eval: Med f/u Rev 7-26-05 L Angelini



STATE OF NEW HAMPSHIRE DEPARTMENT OF CORRECTIONS

Human Resources Bureau P. O. Box 1806

Concord, New Hampshire 03302-1806 FAX: (603) 271-3345 Lisa Currier Administrator

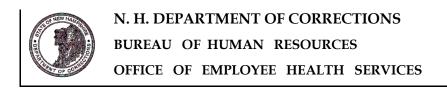
Audiology Referral Memorandum

То:				
From:	Lisa Angelini, RN/CNA, BC Administrator, Employee Health Services	At:	NH DOC Employee Health Services Phone: 271-5661	

Subject: Recourse Testing/evaluation and correction

The results of the audiology screening performed as part of your pre-assignment physical examination indicate that you have not met the standards established by the Police Standards and Training Council. As you were previously informed , passing the physical examination is one of the mandatory requirements for the position which you applied for. Therefore, the following steps must be taken for you to pass the physical and meet the established standards.

- 1. Notify your DOC recruiter **within five (5) days of the receipt of this notice** to confirm your intent to continue with the hiring process.
- 2. Make an appointment with a licensed audiologist for recourse testing. There are specific examination requirements which are outlined in the attachment. **Be sure to give this attachment to the audiologist at the time of your examination.** Should either of you have any questions or concerns about the process please call The Administrator of Employee Health Services for clarification.
- 3. Have the audiologist submit the results of the examination directly to the Administrator of Employee Health Services at the address at the top of this memorandum. Results may also be faxed to the number indicated above, but the original document must also be mailed to the address at the top of this memorandum.
- 4. Once the results are reviewed you shall be notified as to whether or not you have met the medical standard.
- 5. PLEASE NOTE: This testing will not be paid for by the N. H. Department of Corrections; it will be at your own expense.
- 6. If we do not hear from you in the time frame specified above we will conclude that you are no longer interested in pursuing employment with the Department of Corrections.



Recourse Testing: Audiology Requirements (per N.H. Police Standards and Training Council)

1. Audiological examination

Administered by a licensed audiologist performed in a sound treated environment meeting the 1969 ANSI or any subsequent standard and is to include:

- Hearing sensitivity
- Speech discrimination in quiet conditions

The CID W-22 word list should be presented at 50 DB HL via a calibrated speech audiometer through a single speaker stationed at zero degrees azimuth with the candidate seated at approximately one meter (39 inches) from the speaker.

• Speech discrimination in noisy conditions

Speech (hearing) discrimination testing in a background of broadband noise shall be conducted in the same sound field environment. Using a different version of one of the CID W-22 word lists presented at 50 DB HL, a competing noise should be simultaneously presented at 40 DB HL (S/N \pm 10) through the same speaker (zero degrees azimuth) as the test words or through a separate speaker located at 180 degrees azimuth.

NOTE: An open-test response format must be utilized with the candidate responding in writing.

2. Hearing Aid Suitability

• Biological (HAC-B)

Use of hearing aids to achieve standards are permitted as long as they are self-contained and fit within (auricular) or behind/over (post auricular) the ear.

and

• Acoustical (HAC-A)

Candidates with hearing aids shall provide evidence from a licensed audiologist, using functional gain or real ear measurements, that such aid(s) meet the stipulated manufacturer's standards and have automatic shutdown capabilities.

Please document test results as percentages.

Questions should be directed to L. Angelini, RN/CNA, BC (603) 271-5661



N. H. DEPARTMENT OF CORRECTIONS

OFFICE OF EMPLOYEE HEALTH SERVICES

Hepatitis B Vaccine Administration: Informed Consent/Refusal

Name:		DOB:	Height:	Weight:
ALLERGIES:				
I have received written info opportunity to ask question	_		_	
SECTION I Informed Co	onsent			
I request to receive the Energi- immunity. I understand that i effects from the vaccine. I und employment with the NH Dep	immunity is not guara lerstand that my right	nteed. I understanto receive all three	d that I may exp	perience any of the side-
Employee Name		Employee Signature		Date
SECTION II Vaccination	Record			
Vaccine #1	Site	Lot #	Date	Administered by:
#2				
#3				
SECTION III Informed Real I understand that due to an order be at risk for acquiring Hepati at no cost to myself. Despite the in the future, I remain in an order at with blood, I understand	ccupational exposure to tis B infection. I have he risks of exposure a eccupation where there	been given the opp nd possible infectio is a potential for ex	ortunity to rece n, I decline the posure to blood	eive Hepatitis B vaccination vaccination at this time. If, d or body fluids contami-
Employee Name		Employee Signa	ture	Date